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THE CHALLENGES FACED BY THE LGBTQIA+ POPULATION ON THE ACCESS OF THE BRAZILIAN UNIFIED HEALTH SYSTEM: A SYSTEMATIC REVIEW

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ABSTRACT

The LGBTQIA+ population has been a neglected, excluded group and a target of discrimination and prejudice trhoughout history. With an analysis of current disadvantages suffered by the community in Brazil, there are multiple social and political aspects that perpetuates inequality andexclusion from society. Healthcare is a right to all citizens and a state duty, guaranteed through social and economic policies that minimize health risk and other consequences, and in Brazil, with the Unified Health System (SUS), itallows every citizen the access to this social right. However, gender and sexual minorities still face some obstacles to full, universal and equal access to it. The goal of this study is to verify, through literature reviews, which are the main challenges faced by lesbians, gays, bissexuals, transvestites and transsexuals as users of the Unified Health System.

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INTRODUÇÃO

The initials LGBTQI+ is represented by the lesbians(homossexual or homoafective women), the Gays (homossexual ou homoafective men or women), the Bissexuals (people who feel atraction to 2 or more genders), the Transsexuals (individuals who identify with a different gender besides the one assigned at birth), the Queers (an umbrella term for gay) and the Intersexuals (people with a pair of genitalia and/or sexual ambiguity). There are other groups symbolized by the "+", like "Panssexuality" (people attracted to all genders and/or individuals independently of gender)and "Assexuality" (individuals on a spectrum that have little or no sexual interest in someone) (HAFEEZ, *et.al.,* 2017) (NOGUEIRA, *et al,* 2010). Moreover the initial LGBTQI+ tackles important concepts about gender and sexuality, which are necessary definitions to better comprehend the LGBT+ community and its branches. Gender is based on the autoidentification, the sexual orientation is the affective and sexual attraction of the individual to another person.

Both definitions are not codependent, in fact, there are no patterns that determine sexual orientation based on a person's gender (JESUS, 2012). Healthcare is a right to all citizens and a state duty, guaranteed through social and economic policies that minimize health risk and other consequences, also by the universal and equal access to services for its promotion, protection and recovery (BRASIL, 1988, art. 196, inc. IV). To be able to allow every citizen the access to this social right, 31 years ago, through the Health Organic Law 8.080/90, the Unified Health System was created. However, gender and sexual minorities still face some obstacles to full, universal and equal access to it. The gays, lesbians, bissexuals, transvestites and transsexuals population has been a neglected, excluded group and a target of discrimination and prejudice, associated with the HIV/AIDS pandemic and prostitution. Furthermore, to this day, there is a great number of scientific agenda perpetuating such misconception (TORRES, 2020). Considering the necessity of new health policies promotions to overcome the prejudice and discrimination, through a change of society's values based on the respect of differences,the National Policy of Health Integrity for the LGBT Population was developed (BRASIL, 2011).

This LGBT policy recognizes the impacts of prejudice and exclusion at the genesis of the health-sickness process on this population and has as its goals to attract health professionals to the specific demands of the group. The goal of this study is to verify, through literature reviews, which are the main challenges faced by lesbians, gays, bissexuals, transvestites and transsexuals as users of the Unified Health System.

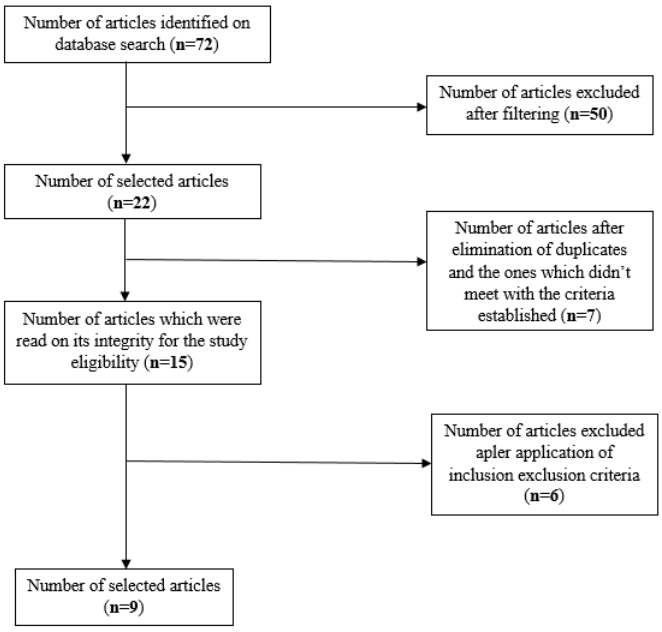
MATERIALS AND METHODS

Search Strategy: It was composed of a studies' systematic review about the challenges faced by the LGBTQIA+ population on the access of the Unified Health System. The articles were chosen on the following databases: BVS, Scielo and CAPES. The keywords LGBT, atendimento e SUS were utilized. It was applied such search filters: articles that were published in the last 5 years before the search date (03.25.2021) and in the portuguese and english language.

Criteria of Inclusion and Exclusion: The criteria of inclusion in the systematic review were the following: studies about the challenges suffered to get equal access by the LGBTQIA+ on the brazilian Unified Health System. There were only accepted studies in the english and portuguese language that included the specific objective of this present review. It was excluded articles that appeared twice on the search and the ones who didn't share the same specific theme or systematic reviews.

RESULTS

At the start of the bibliographic research, 72 articles were found on the Scielo, BVS Portal and Capes Periodic Portal databases, with the keywords "LGBT", "atendimento" and "SUS" , and its boolean operator was "AND". After filter applications suchs as selecting the ones published in all languages in the last five years, 22 were selected, and between those, 3 were excluded for being duplicated and another 4 were discarded for not applying to the general theme. Fifteen articles were selected to verify the eligibility of the search by the full-text reading. After the reading in its integrity, 6 articles were declassified after the application of the inclusion/exclusion criteria. Finally, a total of 9 articles were selected for this study. The search results are presented on the flowchart 1.



Flowchart 1. Process of article selection

Changes on public policies and constitutional rights: The brazilian Unified Health System (SUS) is based off of three orienting principles: university on access, known as "guaranteed access of all the populations in all levels of assistance to health services with no prejudice or privileges"; the integrity of access, approaching an articulate and continuous set of preventive actions and healing services focused on the individual and the collective in all levels of the system complexity and the community's institutionalized participation through regulated law based on the national health councils and conferences- Law no 8.142, 28th of december 1990 (BRASIL, 1990, art. 7.o, inc. I, II, IV IX). With that in mind, due to the challenges that the LGBTQIA+ has been suffering in the Unified Health System, there was a necessity to apply news ways for the equity principle of SUS to be secured and respected to every citizen besides gender or sex orientation. Correspondingly, in the last two decades, there were campaigns that related with the purpose of inclusion of this marginalized group. In 2002, The National DST/AIDS program of the Health Ministry launched the campaign "Health Professional: every homossexual has a right to equal and respectful treatment". In 2004,the Human Right Special Secretariat of the Nacional Presidency launched the program "Brazil without Homofobia" and in 2009, it was developed "the National Plan of Citizenship Promotion and Lesbians, Gays, Bissexuals, Transvestite and Transsexuals Human Rights", and, at last, in 2011 the Health Ministry issued the National Policy of Health Integrity for the LGBT Population. (GUIMARÃES, 2017) On the constitution, in 2011, it was implemented the National Policy of Health Integrity for the LGBT Population, that emerged with the goal of health integrity promotion to lesbians, gays, bissexuals, transvestites and transsexuals, aiming to eliminate institutional prejudice and discrimination, as well as contibuting to lessening inequality and to consolidate SUS as an whole and equal universal system. In a practical form, there are 24 items on the second article of the document that contemplate specific objectives to achieve equality, besides specific competences for the federal, state and municipal health spheres.

Challenges Faced by the Lgbtqia+ Community: The challenges faced by the LGBTQIA+ population are represented by multiple public areas, mostly within the public health services. Defiances such as absence of capacitation, cultural aspects and the lack of receptivity prevents this group of its full rights (PAULINO, *et al,* 2019). At the expense of current weakened policies in allowing equal access, they remain at the mercy of a heteronormative and excludent symbolic violence (FERREIRA, *et al,* 2017). This limits them to a precarious and insufficient service, based on greater physic limitation, incapacity rates and worse general health compared to the heterossexual population (PAULINO, *et al,* 2019). For these reasons, there is an urgent need for an analysis surrounding the biggest challenges faced by the LGBTQIA + on SUS access. The lack of health professional's capacitation involving healthcare in the Unified Health System reaches many branches, since the arrival of a LGBTQIA+ individual on a "UBS" (Basic Healthcare Station) to its contact with the responsible medical professional (FERREIRA, *et al,* 2017). According to Paulino, the main topics discussed by doctors when confronted with a LGBT patients would be the "indifferencespeech" and "unavailability speech". The first one is based on the supposed absence of healthcare differences between the LGBT population and the heterossexual group assisted by them, a generalized premise, characterized by an ideal on which all subjects, besides social and cultural aspects, are treated the same (OLIVEIRA, 2019), such ideal should be desconsideraded because of the already proved importance of an specialized care, since the greater risk of bad health conditions compared to other social groups (FERREIRA, *et al,* 2017) . The latter tries to justify a notable lack of sexual and gender minorities in public health services; doctors interviewedexalted the subject's autonomy in regards to his experiences in health centers. However, based on Ferreira, minority groups within this community are presented with many barriers and challenges duringmedical care. Lesbians are discouraged to reveal their sexual orientation, pointed by Guimaraes' study, in which 40% of lesbian and bissexual women did not reveal their sexual orientation during treatment, making the process of care and diagnoses more difficult, since about 17% of the cases, the women noted that there were an deficiency on exam solicitation.

They go against the mere reproductive approach to the feminine figure and even the possible presumption of heterossexuality withdraws them to an adequate bond with their health professional. Effeminate gays suffer from a double judgment, one for not following the heteronormative standard and for associating with a feminine ideal, which puts women in a place of subservience based on the paradoxical masculine dominance presumption. These oppressive and misogynistic attitudes of health professional influence significantly on the physical and psychological health of the group, with them being more susceptible to depressive behavior, anxiety disorders and excessive fear related to the violent actions witnessed (FERREIRA, *et al,* 2017). Transsexuals and transvestites have as a major challenge: the transfobia, showed by actions like the lack of social name use by doctors and other professionals when refering to them, somewhat based on the former educational journey and by certain religious beliefs, making it difficult for the patient to keep participating on health promotion pratices their will to maitain treatment, since a transsexual patient on SUS, according to Cruz, must be able to recieve an integrated care, such as hormonotherapy and sex reassignment surgery. Therefore, these examples affirm the difficulties the subjects involved in the management process of SUS remain an obstacle to an adequate patient's hearing and recognizing the demands of the LGBTQIA+ community (GOMES, 2018), perpetuating the weakened bond between the patient and the health professional (FERREIRA, *et al,* 2017). In relation to the origin and development of prejudice and exclusion of the LGBTQIA+ population, its base is related to traditional and heteronormativeconcepts for health assistance (OLIVEIRA, 2019), and it covers aspects af affectivity, with rejection of homossexuality, and cultural and cognitive aspects, shown by the lack of tolerance to any type of political or social action that would allow equal rights (GUIMARÃES, 2017). These archaic ideals contribute not only for a bigger exclusion, but also to perpetuate symbolic violence on health centers, a place in which should be centered on inclusion, tolerance and respect towards sexual minorities (FERREIRA, *et al* 2017). Through gestures like looks of disapproval and LGBTfobic speech made by SUS' professionals, factors like maintenance of treatment and chances of patients' return to the health center are negatively influenced (FERREIRA, *et al* 2017). According to Gomes, the people related with the SUS administration demonstrate difficulty on making an active hearing of the patient, as well as recognizing the most urgent demands and necessities of the LGBT community, as demonstrated on the interviews presented, whose interviewees felt nervous and insecure about being questioned on the adequate conduct towards the group. Therefore, it is essential the presence of receptive professionals to new forms of learning and sensitized about respect of diversity to a better and integrated healthcare offer (GUIMARÃES, 2017).

Once highlighted the presence of excludent and prejudiced behavior of health administrators, it is vital to conduct an analysis surrounding the consequences of such practice. On the behaviours towards lesbians and bissexuals women, Guimaraes states that 40% do not reveal their sexual orientation, making the professional obtain an deficient notion about the patient's life habits and background, noted by the fact that 17% of interviewed women affirm insufficiency on the number of exams proposed by the doctor for posterior evaluation. The exam's coverage in relation the heterossexual women is alvo divergent, which are highlighted on the different rates on pap smears, being performed on 89,7% of the heterossexual women and in 66,7% on lesbians and bissexual women (GUIMARÃES, 2017). However, although it is not necessary such distinction on the approach between gynecological appointments on both groups, it has become apparent that the professional should be aware of the patient's sexual orientation, with the goal of diminishing heteronormative thinking and to comprehend the risks related to certain sexual pratices (FERREIRA, *et al* 2017). In addition, the trans population, who is in need of a multi branched treatment, need specific and directed care (FERREIRA *et al* 2017). The LGBTQIA+ first-aid rooms appeared withthe National Policy of Health Integrity for the LGBT Population in 2011, having as a goal to become a social support and protection for promotion of health with a wide variety of specialists like speech therapists, psychologists, gynecologists, proctologists and plastic surgeons. Nevertheless, the provided care is weak, even on first-aid rooms focused on LGBT care and its users report the absence of social name use when in a conversation with a transgender individual by the Unified Health System administrators, disfavoring a possible bond with offered health services and inhibiting future permanece on treatment (FERREIRA, *et al* 2017). As stated by Ferreira,the health professional 's use of social nome when talking to a transgender person is extremely important because facilitates equity practices, guarantying respect and life appreciation, and promotes trans inclusion in multiple social equipments. In conclusion, the significance of an inclusive and receptive treatment is in assuring the feelings of acceptance and belonging of the user in the environment in which they seek healthcare.

The first LGBTQIA+ social movements started in the 1980s, together with the beginning of HIV/AIDS pandemic, and yet, only in 2004, with the Brazil Without Homofobia Program on Lula's administration (2003-2010), there was the establishment of a wider agenda surrounding LGBTQIA+ citizenship. With this program, the LGBT Reference Centers emerged. They focused on offering services on juridical, psychological and socioassistencial areas, orienting and referring LGBTfobic violence survivors to health centers, guardianship centers and public defender's offices. Moreover, these centers also manage to promote courses, discussions, seminars, campaigns, intervention on companies that violateLGBT work rights, and elaborate educational approaches about gender and sexual diversity (FEITOSA, 2019). On a scientific research originated in Pernambuco, Brazil Reference Center, besides current members showing satisfaction on the center's potential and its impact on intervening on public policies, former members share a different perspective, emphasizing the precariousness on the center's management, due to payment delays, inadequate structure and lack of knowledge of gender and sexual diversity from the many institutions which the center associated with; considering the absence of social solidarity with the group, on the grounds of a conservative wing ingrained in the country and with the Catholic Church's influence, disregarding the demands of each LGBTQIA+ subgroup (FEITOSA, 2019). When analyzing possible alternatives to revert the consequences of inadequate assistance provided by health professionals, it is crucial to make training strategies feasible, focusing on how to offer advice and an inclusive care based on the necessities of the LGBT group (DULLIUS, *et al,* 2021). This training is based on current knowledge and perceptions of the health professionals interviewed and, depending on the results, it will mold the learning strategy according to their beliefs and previous understandings, allowing a focused and effective process of understanding (DULLIUS, *et al,* 2021). Another strategies, such as the one recommended by the National Policy of Health Integrity for the LGBT Population, although the topic still remains marginalized and excluded from big national discussions, is to qualify and discuss the thematic on health and educational scopes, providing a better notoriety to the topic and guaranteeing a better approach and welcoming ofLGBTQIA+ patients in the Unified Health System (ALBURQUERQUE, 2019).

Conclusion

Through the challenges observed in the studies, it was highlighted the discrimination, the homofobia, the absence of the team's training and the presumed heteronormativity by the professionals during assistance. According to our results, more studies about the LGBTQIA+'s health conditions is needed and its access to the Unified Health System is extremely important as well as more investments on public policies to achieve effectiveness for them to be able to attend to a greater number of individuals. It has come to an agreement that, besides the current public policies related to sexual minorities, the LGBTQIA+ population still lives with social invisibility that in the Unified Health System reflects on the precarious assistance and in more chances of recurrent bad health conditions, which is against the principles of integrality and equity that the Unified Health System is based on.

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